

South Carolina Department of Health and Human Services Family Planning Application <i>Applicants under age 16 must have the consent of at least one parent or guardian.</i>	DHEC Application Date:
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1. Tell us who you are and where you live.

Name (First, Middle Initial, Last):		Social Security Number: (Required)		Place of Birth: (City, County, State)	
Home Address (include apartment number):		City:	State:	Zip Code:	County:
Mailing Address (if different from above):		City:	State:	Zip Code:	Telephone Number: ()
What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other		Your Full Name at Birth:		Your Mother's Full Maiden Name:	

- 2. Do you have health insurance that covers doctor visits and lab tests?** ☐ YES ☐ NO *If yes, complete the following:*
 Name of Company _____ Policy Number _____ Insured's Name _____
- 3. Are you currently receiving Medicaid?** ☐ YES ☐ NO *If yes, do you have a Medicaid card with you?* ☐ YES ☐ NO
- 4. Have you had a permanent sterilization procedure** (tubes tied, hysterectomy)? ☐ YES ☐ NO
- 5. Are you pregnant?** ☐ YES ☐ NO *Delivery Due Date:* _____
- 6. Are you totally and permanently disabled?** ☐ YES ☐ NO *If yes, are you receiving Social Security Disability Benefits?* ☐ YES ☐ NO
- 7. Do you have children under age 18 living in your home?** ☐ YES ☐ NO
- 8. Tell us information about you and other family members who live with you:** Social Security Numbers are not required for persons who are not applying for Medicaid. *If you tell us the Social Security Numbers, it may help us process your application faster.*

NAME	RELATIONSHIP	BIRTHDATE	RACE	SEX	US CITIZEN?	SC RESIDENT?	MARITAL STATUS	SOCIAL SECURITY NUMBER
1.	Applicant							
2.								
3.								
4.								
5.								
6.								
7.								

- 9. Do you or anyone in your family have income from work or any other source?** ☐ YES ☐ NO *If yes, complete the following:*
 Please provide proof of last 4 weeks of income.

NAME OF PERSON WHO GETS THE INCOME	SOURCE OF INCOME (Social Security, Child Support, etc.)	GROSS MONTHLY INCOME
1.		
2.		

10. Do you pay someone to take care of your child (ren) under age 12? ☐ YES ☐ NO If yes, complete the following:

Please provide proof of last 4 weeks payment.

NAME OF CHILD(REN) RECEIVING CARE (Please attach a sheet for additional children)		
Name: _____ 1a. How much? _____ 1b. Frequency _____	Name: _____ 2a. How much? _____ 2b. Frequency _____	Name: _____ 3a. How much? _____ 3b. Frequency _____

DHEC CERTIFICATION

I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any services provided me. DHEC may exchange medical or other confidential information as necessary to the Center for Medicare and Medicaid Services or its agents needed to determine these benefits for related services. I also agree to participate in treatment plans, assignment of insurance, Medicaid or Medicare benefits to DHEC for services rendered and to participate in payment for services as determined by specific program guidelines.

I _____, understand that I may be eligible for and can be considered for Full Medicaid or SCHIP benefits, but elect to apply for Family Planning Services Only! ☐ YES ☐ NO If no, the application will be considered for Full Medicaid or SCHIP benefits.

(The signatures of Applicant, Authorized Representative, Parent and/or Guardian below indicate that the Rights and Responsibilities on Page 3 have been read and I have been given a copy of the Family Planning Comparison of Benefits letter. When applicable, both the Applicant and Authorized Representative should sign the application.)

Applicant's Signature _____ Authorized Representative's Signature _____ Date _____

Parent's (or Guardian's) Signature: (required if applicant is under 16) _____ Date _____

MAIL FAMILY PLANNING APPLICATION TO:	DHHS USE ONLY
SC Department of Health and Human Services Division of Central Eligibility Processing Post Office Box 100101 Columbia, South Carolina 29202-3101 If questions, please call: 1-888-549-0820 (toll-free number) If applying for other Medicaid programs please send signed application to your local Medicaid Office.	Gross Monthly Earned Income _____ Standard Deduction - _____ Gross Unearned Income + _____ Child Care Deduction - _____ Net Family Income = _____ Income Limit _____

- DHEC/DHHS USE ONLY -

I have reviewed the statements on this form, shared a list of community health centers, given a copy of the Family Planning Comparison of Benefits letter to the applicant, and discussed the importance of getting primary care services with the applicant/beneficiary.

Telephone, including Area Code _____ Date _____

DHEC/DHHS Worker's Signature _____ Location _____

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).
 - a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
 - b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
 - c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
 - d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.
4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.
7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.
8. I know that I may request a hearing if I believe an error has been made in processing my application.

Please tell us where you obtained this application _____